

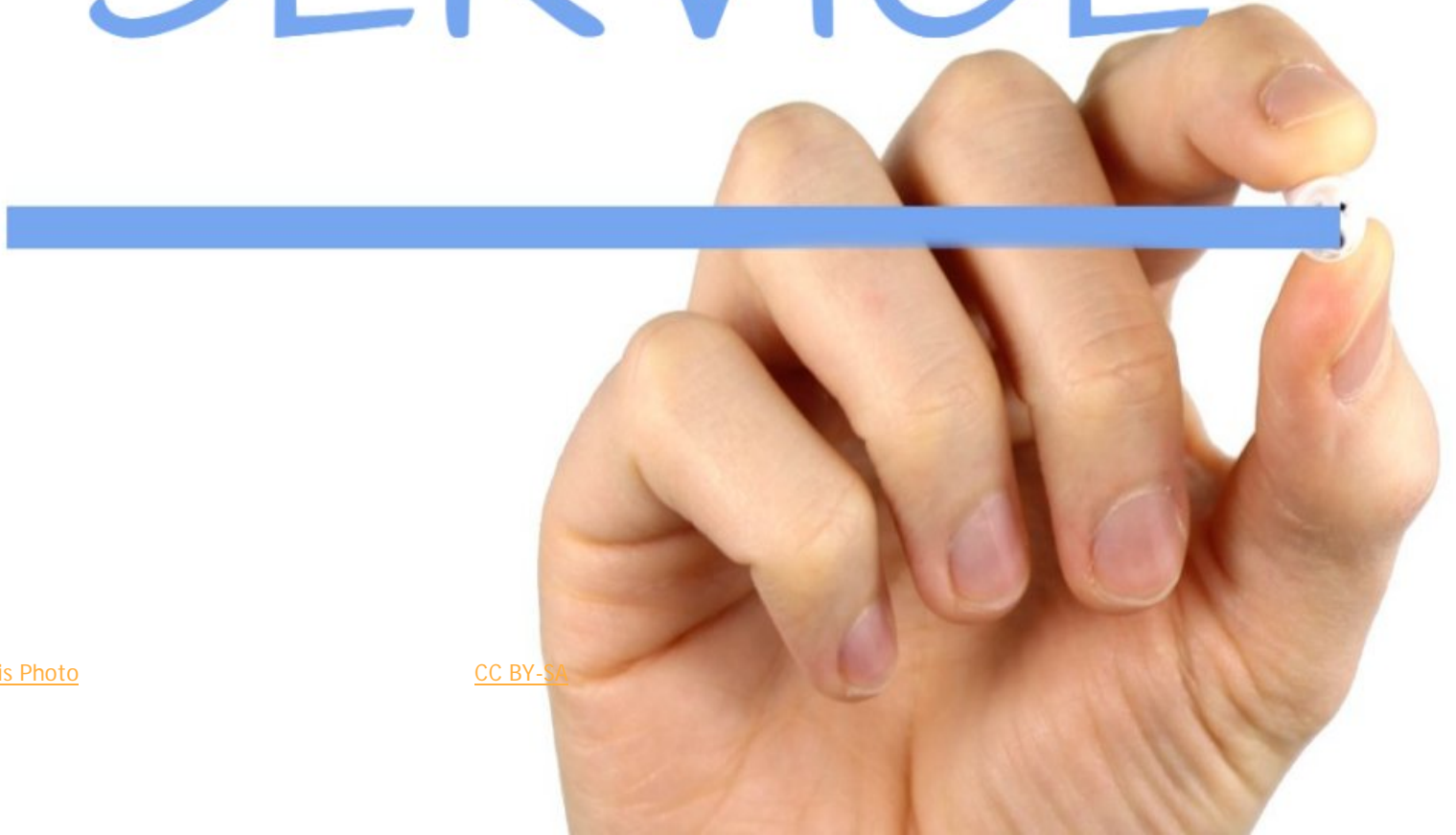
SERVICE - FORMS - LITIGATION - BENEFITS

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Matt Buckner, Department of Justice



CUSTOMER SERVICE



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Third Party Administrator

Sedgwick

Contract Extension 7/1/2023

RFP Fall 2022

Claim Teams

- Team Lead
- Medical Only Examiners
- Lost Time Adjuster
- Claim Assistant

Medical Only Examiners

- Contact WCA to confirm claim--- issues or concerns
- Contact provider for medical records related to injury & document the medical findings in the file notes
- Monitor medical progression of the injured employee's condition until a release from care & claim closure

Lost Time Adjusters

- Contact WCA to confirm facts of incident, issues, concerns, witnesses or video of the incident scene
- Contact injured worker for recorded statement of facts regarding incident to assist (in part) with their compensability decisions
- Follow up with treating MD for medical records to confirm diagnosis, treatment plan & work status
- Prompt and reassuring service to injured worker
- Maintain contact with claimant, employer & MD until MMI is achieved, successful return to work and/or claim resolution

Medical Care Work Related Incident

- Link for the NCDPI Preferred Provider is www.viaoneprovidersearch.net
- Urgent Care or FastMed facilities are preferred for initial medical care
- Emergency Room services should be used for true emergencies
- Include medical treatment facility at time of claim submission. Without this, the Sedgwick system will convert to Incident Only Claim. If you don't know at time of incident, report medical facility to team lead as soon as known

Medical Only v. Incident Only Claims

- MO and IO claims do not require claimant contact
- IO claims are closed at time of online submission
- Medical information affects timeliness of investigations and medical treatment approval
- MO claims – Examiner is required to contact employer and doctor. Injured employee will receive a letter with the examiner's contact information. Injured employee will not receive a phone call from the examiner

FY22



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WC Benefit Payments

Benefit Payments	FY22	FY21
Medical	\$23.2 Million	\$20.3 Million
Indemnity	\$30.6 Million	\$30.5 Million
Other	\$ 4.2 Million	\$ 3.9 Million
Total Benefit Payments	\$58.0 Million \$10.0 Million Local	\$54.7 Million

Open Claims Count

Open Claims	New Claims FY22	All Claims FY22
Open Indemnity	828	2444
Open Medical	976	986
Total	1804	3430 490 Litigated
Settled	\$6.6 Million	



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FORM 22

- Statement of Days Worked and Earnings of Injured Employee
- Proper Completion
- Report Timely

North Carolina Industrial Commission

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

IC File # _____

Emp. Code # _____

Carrier Code # _____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Carrier File # _____

Employee's Name _____

Address _____

City _____

State _____

Zip _____

Home Telephone _____

Work Telephone _____

XXX-XX-

Last 4 Digits of SSN _____

☐ M ☐ F

Sex

/ /

Date of Birth

Date of Injury: / /

Employer's Name _____

Telephone Number _____

Employer's Address _____

City _____

State _____

Zip _____

Insurance Carrier _____

Carrier's Address _____

City _____

State _____

Zip _____

/ /

Carrier's Telephone Number _____

Fax Number _____

Year: 20	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned
Jan.																																
Feb.																																
Mar.																																
Apr.																																
May																																
June																																
July																																
Aug.																																
Sept.																																
Oct.																																
Nov.																																
Dec.																																
Total																																

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: \$ _____.

Average Weekly Wage Calculation

- N.C.G.S. 97-2(5)
 - Different Methods of Calculation
 - Employed for 52 weeks prior to date of injury
 - Fewer than 52 weeks
 - Like-Employee

FORM 19

- Employer's Report of Injury to the NCIC
- Information and Input
- SSN, Claimant Address, Occupation, DOB, Phone Number
- Date you or the supervisor first knew of injury
- Clear Description of Incident
- Specific Body Parts
- Report Timely

North Carolina Industrial Commission

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law. This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name		Employer's Name		() - Telephone Number	
Address		Employer's Address		City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
() - Home Telephone	() - Work Telephone		Carrier's Address	City	State Zip
- - - - -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	() -	() -	
Social Security Number	Sex	Date of Birth	Carrier's Telephone Number	Fax Number	

Employer	1. Give nature of employer's business
	2. Location of plant where injury occurred County Department State if employer's premises
	3. Date of injury / / 4. Day of week Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	5. Was employee paid for entire day 6. Date disability began / /
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9. Occupation when injured
	10. (a) Date employment began (b) Wages per hour \$
	11. (a) No. hours worked per day (b) Wages per day \$ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime \$ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ per
	12. Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
Cause And Nature Of Injury	13. List all injuries and specify body part involved (e.g. right hand or left hand):
	14. Date & hour returned to work / / at : .M. 15. If so, at what wages \$ per
	16. At what occupation 17. Employee's salary continued in full?
	18. Was employee treated by a physician
	19. Has injured employee died 20. If so, give date of death (Submit Form 29) / /
Fatal Cases	
Employer name Signed by	Official Title Date Completed / /

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:	Address: Street/City/Zip/Telephone		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Split Funding

- Calculate Gross Wages at 52 weeks prior to date of injury
- Review state paid wages against all other wages
Determined by "Bucket Codes"

EXAMPLE:

\$30,000 gross - \$400 local = \$29,600 state

$\$29,600 / \$30,000 = 98.66$

98.66% @ state funded

1.34% @ locally funded

Split Funding

- Percentages calculated to be included on the Form 19 / FNOL (First Notice of Loss)
- Submit payroll information when claim is filed
- When wage documentation is requested and not received, claim will be entered as 50/50 split until resolved



LITIGATION

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The Workers' Compensation Litigation Process

- Hearings Before the Industrial Commission
 - Overview of Process
 - Preparing to Appear at Hearing
 - What to Expect when you are Called to Testify
 - Testifying Tips
 - Direct Examination
 - Cross Examination
 - Questions from the Deputy Commissioner
 - What Happens After the Hearing

500 Week Claims

- Claimant's Responsibility for Continuation of WC Benefits
- Helpful Evidence
 - Job Application
 - Employment File

A person wearing a dark blue suit, a light blue shirt, and a red tie. Their right hand is extended forward, with the index finger pointing towards the text. The background is a solid light blue.

EMPLOYEE BENEFITS

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Continuation of Benefits

While on workers' compensation...

- Performance Increases
- Vacation & Sick Leave
 - accumulating leave v. earned leave
- Retirement Service Credit
- Longevity
- Retirement

State Disability Benefits

Short Term Benefits

Establish Date of Disability

Long Term Benefits

Resign

Eliminate ---

~Health Insurance Premium

~Accumulation of
Vacation/Sick Leave

Separation Due to Unavailability

TTD Benefits Continue

- Claim Accepted Prior to a Dismissal
- Separation Due to Unavailability
- Employee Retires
- No Returned to Work

Claims Become Expensive

- Employee doesn't apply for State Disability Benefits
- Employee Retires and Continues to Collect TTD
- Employee Doesn't Return Back to Work
- Employee becomes eligible for SSDI
- Medicare Eligible



Automatic Deposits

- We are working on...
 - Automatic Deposits for Indemnity Payments
 - Claimant MUST individually sign up and MUST provide requested banking details
 - DPI will advise WCAs when process is initiated

Cost Containment Strategies

**Beginning
Of
The
Claim**

Investigate
Report Claim

**Middle
Of
The
Claim**

Monitor Claim
Monitor Medicals

**End
Of
The
Claim**

Settle

THANK YOU

Together
WE
Achieve
More



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